



University Recommendation for School Counselor Endorsement

This statement must be prepared and signed by the appropriate official from the college or university where your School Counselor Program was completed.							
Candidate Information:							
Last Name			First Name			MI	
Address			City		State	Zip Code	
Last Four Digits of SSN		Birth Date		Former Name(s)			
To be completed by the college or university where the applicant completed his/her School Counseling Program. Please complete the information requested below and mail this form to the candidate at the address listed above							
IF you have any questions while completing this form please call the Montana Office of Public Instruction/Educator Licensure at 406-444-3150							
Name of College/University							
City/State							
Is your institution regionally accredited?			<input type="radio"/> Yes <input type="radio"/> No	Name of regional accreditation agency:			
Accreditation of School Counselor Preparation Program		<input type="radio"/> CACREP <input type="radio"/> NCATE <input type="radio"/> State <input type="radio"/> OTHER (Please provide information) _____					
Type of Master's degree completed by candidate:			<input type="radio"/> School Counseling <input type="radio"/> Other (please describe) _____				
Number of internship hours in a school setting			_____ Hours				
<input type="radio"/> I attest that the above named candidate completed a School Counseling program.							
Signature					University Seal		
Printed Name							
Title		Phone Number					
Email Address		Date					